FOOD AND DRUG ADMINISTRATION (FDA)
RECALLS/ALERT NOTICES

1. **FDA MEDICAL EQUIPMENT RECALLS AND ALERTS**. The following recalls are reported in accordance with AFMLL 2-95, page CE-4, and should be treated as directed modifications in accordance with that AFMLL and AFI 41-201, Chapter 2, Section D. If you possess any of these items and have not received recall notification, you should contact the manufacturer for recall instructions. Suspension is only required for Class I items. (FOM, Capt David Zemkosky, DSN 343-4028)

CLASS I RECALLS: None

CLASS II RECALLS:

6525NS

MDC 16602	X-Ray Generators
PRODUCT	X-Ray Generator, Model No. CP700. Recall #Z-142-7.
CODE	All units.
MANUFACTURER	Gendex-Del Medical Imaging Corporation, Franklin Park, Illinois.
RECALLED BY	Manufacturer. FDA approved the firm's corrective action plan on November 20, 1996. Firm-initiated field correction ongoing.
DISTRIBUTION	Nationwide.
QUANTITY	Undetermined.
REASON	Noncompliance with performance standards for x-ray products in that selection of one of the 3,072 possible selectable exposure conditions failed to meet the firm's accuracy claim for mAs selection.

[ ] None Present
[ ] Action Taken _____
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6515NS

MDC 13217	Infusion Pumps, Syringe
PRODUCT	Baxa Model 60001, Dual Rate Syringe Infusers, used for the administration of IV drugs. Recall #Z-132-7.
CODE	Serial numbers: 2001 through 2089 2122 through 2181 2194 through 2264 2266 through 2365 2367 through 2438.
MANUFACTURER	Baxa Corporation, Englewood, Colorado.
RECALLED BY	Manufacturer, by telephone on August 23, 1996. Firm-initiated recall ongoing.
DISTRIBUTION	Nationwide.
QUANTITY	392 units were distributed.

REASON The device has the potential to run at twice the speed for which it is set.

[ ] None Present
[ ] Action Taken _____
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6515NS
MDC 13215 Infusion Pumps
PRODUCT EZ Flow 480 Ambulatory Infusion Pumps containing software versions 2.2c or earlier. Recall #Z-133-7.
CODE Various serial numbers with software version 2.2c or earlier.
MANUFACTURER Gish Biomedical, Inc., (formerly Creative Medical Developments, Inc. (CMD)), Nevada City, California.
RECALLED BY Manufacturer, by telephone on February 23, 1996 and March 1 and 18, 1996. Follow-up letters were sent on June 11, 1996 and August 2, 1996. Firm-initiated recall ongoing.
DISTRIBUTION Nationwide and international.
QUANTITY 577 units were distributed.
REASON Due to a software error, the EZ-480 exhibits a faulty infusion rate when placed in the pause mode and subsequently restarts.

[ ] None Present
[ ] Action Taken _____
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CLASS III RECALLS: None

MEDICAL EQUIPMENT SAFETY ALERTS: None

2. DRUG/SUPPLY PRODUCT RECALLS AND MEDICAL INFORMATION. The Food and Drug Administration (FDA) advises that the drug products listed below were recalled by the manufacturers or distributors concerned. The FDA has classified these recalls as follows:

CLASS I: A situation in which there is a reasonable probability that the use of, or exposure to, a violative product will cause serious, adverse health consequences or death.

CLASS II: A situation in which the use of, or exposure to, a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.

CLASS III: A situation in which the use of, or exposure to, a violative product is not likely to cause adverse health consequences. Most of these items are nonstandard, and the possibility exists that medical activities may have purchased them locally. There is also a possibility that some of these items have NSNs assigned and may have been reported in earlier Q.A. messages. Activities having quantities of [AU1]these items on hand will immediately suspend the materiel from issue and use. CONUS activities will contact the nearest office of the respective manufacturer or distributor for disposition instructions. OVERSEAS activities will report quantities suspended to AFMLO/FOCO no later than 24 FEB 97 for disposition instructions. They should include nomenclature; lot number; manufacturer; quantity suspended; strength size; requisition; and DPSC purchase order number, contract number, and stock record account number (SRAN). (FOM-P), Bonnie Phillips, DSN (343-4170)

CLASS I RECALLS: None

CLASS II RECALLS:

NSN	**6505 Nonstandard**
PRODUCT	**Solopak Sodium Chloride Injection USP, 0.9%, preservative free, packaged in 2 ml, 3 ml, and 10 ml pre-filled syringes, used for diluting or dissolving compatible parenteral medications. Recall #D-039-7.**
CODE	**Lot numbers: 96E002B, 96E004B, 96D015B.**
MANUFACTURER	**SoloPak Medical Products, Franklin Park, Illinois.**

RECALLED BY SoloPak Medical Products, Elk Grove Village, Illinois, by letter dated October 25, 1996. Firm-initiated recall ongoing.

DISTRIBUTION Massachusetts, Wisconsin, Tennessee, Texas, Illinois, North Carolina, New Jersey, Florida, Oklahoma, Louisiana, New York, California, Pennsylvania, Michigan.

QUANTITY 47,520 syringes were distributed; firm estimated that 48 percent of the syringes remained on market at time of recall initiation.

REASON Lack of adequate assurance of sterility.

[ ] None Present
[ ] Action Taken _____

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NSN 6505 Nonstandard

PRODUCT (a) Whole Blood; (b) Red Blood Cells; (c) Red Blood Cells, Deglycerolized; (d) Platelets; (e) Platelets, Pheresis; (f) Fresh Frozen Plasma; (g) Single Donor Plasma Liquid; (h) Cryoprecipitated AHF; (i) Recovered Plasma. Recall #B-534/542-6.

CODE Contact FDA, Center for Biologics Evaluation and Research, Office of Compliance (301) 594-1191 for individual unit numbers recalled.

MANUFACTURER The American National Red Cross, Arlington, Virginia.

RECALLED BY Manufacturer, by letters from 1988 through 1995. Firm-initiated recall ongoing.

DISTRIBUTION Nationwide and international.

QUANTITY Approximately 11,286 units of various blood products were distributed.

REASON Blood products tested negative for the antibody to the human immunodeficiency virus type 1 (anti-HIV-1) and the hepatitis B surface antigen (HBsAg) but were collected from donors who previously tested repeatedly reactive for anti-HIV-1 or HBsAg and had confirmatory testing inappropriately repeated or indeterminate Western blots incorrectly interpreted as negative.

[ ] None Present
[ ] Action Taken _____

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NSN 6505 Nonstandard

PRODUCT (a) Albuminar-25; (b) Albuminar-20; (c)

	Albuminar-5; (d) Monoclate-P; (e) Plasma Plex. Recall #B-026/030-7.
CODE	**(a-c & e) All in-date lots; (d) Lot #P72304.**
MANUFACTURER	**Centeon L.L.C., Kankakee, Illinois.**
RECALLED BY	**Centeon L.L.C., A company of Armour and Behring. King of Prussia, Pennsylvania, by telephone on September 20, 1996, and by letters on September 23 and 24, 1996, and October 4, 1996. Firm-initiated recall ongoing. See also FDA talk paper T96-67, October 4, 1996.**
DISTRIBUTION	**Nationwide and international.**
QUANTITY	**18,508 - 50 ml vials and 1,677 - 500 ml vials of 5%, and 70,922 - 50 ml vials and 52,135 - 100 ml vials of 25% Albuminar in the dropped lot category were distributed. The firm estimates that 30% of the vials remain on the market; 1,595 vials of Monoclate-P were distributed, with the firm estimating that 250 vials remain on the market. The amount of Albuminar and Plasma Plex distributed is not available at this time. The firm estimates that 30% of the distributed product remains on the market.**
REASON	**Biological products that are sensitive to environmental contamination may not have been processed according to current Good Manufacturing Practices.**

[ ] None Present
[ ] Action Taken _____
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NSN	**6515 Nonstandard**
PRODUCT	**Stainless Steel Greenfield Vena Cava Filter with 12 French Introducer System, a permanently implanted device designed to protect against pulmonary embolism while maintaining patency of the vena cava. Recall #Z-146-7.**
CODE	**Catalog #50-400. All lots.**
MANUFACTURER	**Boston Scientific Corporation, Watertown, Massachusetts.**
RECALLED BY	**Boston Scientific Corporation, Natick, Massachusetts, by letters on April 29, 1996, and October 26, 1996. Firm-initiated recall ongoing.**
DISTRIBUTION	**Nationwide and international.**
QUANTITY	**4,898 devices were distributed.**
REASON	**The guidewire can become wedged in the apex of**

the vena cava filter using the jugular approach.

[ ] None Present
[ ] Action Taken _____
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NSN	**6530 Nonstandard**
PRODUCT	**Devon Point of Use Cabinet: (a) Model Reorder No. 4842; (b) Model Reorder No. 4844, an accessory to the Devon Point of use Sharps-a-Gator. Recall #Z-140/141-7.**
CODE	**All lots.**
MANUFACTURER	**Graphic Controls (Devon Industries), Chatsworth, California.**
RECALLED BY	**Graphic Controls Corporation, Buffalo, New York, by visit and by letters dated August 26, 1996, and September 4, 1996. Firm-initiated recall ongoing.**
DISTRIBUTION	**Nationwide and international.**
QUANTITY	**(a) 10,840 cabinets; (b) 2,580 cabinets were distributed.**
REASON	**The solid color of the door of the sharps container cabinet may affect the ability of the user to determine the fill level of the needles and syringes allowing for the potential of needlestick injuries.**

[ ] None Present
[ ] Action Taken _____
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NSN	**6550 Nonstandard**
PRODUCT	**Opus Rubella Test Modules and Opus Rubella-M Test Modules: (a) OPUS* Rubella Test Modules, Catalog No. 464-050, (b) OPUS* Rubella-M Test Modules (Foreign Distribution), Catalog No. OWUX/25 and OWUX/45. Recall #Z-148/149-7.**
CODE	**Lot numbers: (a) Lot Nos. RBC6, RBC9, RBD3, RBD4, RBD5, RBD6; (b) RMC8, RMC9.**
MANUFACTURER	**Behring Diagnostics, Inc., Westwood, Massachusetts.**
RECALLED BY	**Manufacturer, by telephone on October 29, 1996, followed by letter. Firm-initiated recall ongoing.**
DISTRIBUTION	**Nationwide and international.**
QUANTITY	**Quantity estimated in distribution: RBC6 5 boxes; RBC9 11 boxes**

	RBD3 13 boxes; RBD4 26 boxes **RBD5 39 boxes; RBD6 72 boxes** **RMC8 2 boxes; RMC9 54 boxes.**
REASON	**Negative control yielded indeterminate results, and there was a high incidence of false positive test results.**

[ ] None Present
[ ] Action Taken _____
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NSN	**6550 Nonstandard**
PRODUCT	**MPI MAA Kit, for the preparation of Technetium Tc 99m Albumin Aggregated Injection, in multidose vials containing 2.5 mg albumin aggregated, 5.0 mg albumin human, 0.06 mg stannous chloride, and 1.2 mg sodium chloride. Recall #D-046-7.**
CODE	**Lot numbers: V-1298 EXP OCT 04 96, V-1381 EXP FEB 07 97, W-0069 EXP FEB 21 97 W-0289 EXP MAR 21 97.**
MANUFACTURER	**Merck Frosst Canada, Inc., Quebec, Canada.**
RECALLED BY	**Medi-Physics, Inc., an Amersham company, Arlington Hts., Illinois (own label distributor), by telephone on November 12, 1996. Firm-initiated recall ongoing.**
DISTRIBUTION	**Nationwide and Hong Kong.**
QUANTITY	**2,423 kits were distributed; firm estimated that very little, if any, product remained on market at time of recall initiation.**
REASON	**Lack of adequate assurance of sterility of the human albumin component manufactured by Centeon, Kankakee, Illinois.**

[ ] None Present
[ ] Action Taken _____
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CLASS III RECALLS:

NSN	**6505 Nonstandard**
PRODUCT	**E-Z-EM brand barium sulfate suspensions, Rx, contained in 64 fluid ounce HDPE jugs: (a) Liquid Polibar Plus; (b) Liquid E-Z-Paque; (c) E-Z-AC. Recall #D-040/042-7.**
CODE	**(a) Catalog #L168, Lot numbers: 1B8693A, 1B8693B, 1B8693C, 1B8694A, 1B8694B, 1B8694C, 1B8695A, 1B8695B and 1B8695C. All lots expire 1/97; (b) Catalog #L186, Lot numbers: 4B8690, 4B8691, 4B8692 (expire 4/97), 5B9050, 5B9051 and 5B9052 (expire 5/97); (c) Catalog #L178, Lot numbers: 1B8669A, 1B8669B, 1B8669C (expire 1/97), 2B8670A, 2B8670B, 2B8670C (expire 2/97), 2B8671A, 2B8671B, and 2B8671C (expire 2/97).**
MANUFACTURER	**Therapex, Division of E-Z-EM Canada Inc., Providence of Quebec, Canada.**
RECALLED BY	**E-Z-EM, Inc., Westbury, New York (distributor), by telephone on October 9, 1996, followed by letter october 22, 1996. Firm-initiated recall ongoing.**
DISTRIBUTION	**Nationwide.**
QUANTITY	**Volume of product in commerce: (a) Liquid Polibar Plus, Catalog #L168 1B8693A: 140 units 1B8693B: 149 units 1B8693C: 98 units 1B8694A: 146 units 1B8694B: 142 units 1B8694C: 111 units 1B8695A: 144 units 1B8695B: 157 units 1B8695C: 109 units (b) Liquid E-Z-Paque, Catalog #L186 4B8690: 435 units 4B8691: 434 units 4B8692: 426 units 5B9050: 428 units 5B9051: 426 units 5B9052: 426 units. (c) E-Z-AC, Catalog #L178 1B8669A: 146 units 1B8669B: 146 units 1B8669C: 111 units 2B8670A: 151 units 2B8670B: 140 units 2B8670C: 10 units 2B8671A: 148 units**

	2B8671B: 29 units **2B8671C: 60 units.**
REASON	**Lots fail specifications for total solids and assay; lots are also clumping and are difficult to resuspend.**

[ ] None Present
[ ] Action Taken _____
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NSN	**6505 Nonstandard**
PRODUCT	**Phentermine HCl Capsules, USP, 30 mg (Blue/Clear), in HDPE bottles of 1,000, Rx product indicated in the management of exogenous obesity. Recall #D-043-7.**
CODE	**Lot No. 6H163 EXP 8/00** **Lot No. 6H164 EXP 8/00** **Lot No. 6H165 EXP 8/00.**
MANUFACTURER	**Eon Labs Manufacturing, Inc., Laurelton, New York.**
RECALLED BY	**Manufacturer, by letter on October 28, 1996. Firm-initiated recall ongoing.**
DISTRIBUTION	**Nationwide and Puerto Rico.**
QUANTITY	**The following quantities were distributed per lot:** **6H163 - 2,395 bottles** **6H164 - 2,458 bottles** **6H165 - 2,447 bottles.**
REASON	**Some lots are labeled with incorrect expiration -- A four-year expiration period was assigned rather than a two-year period.**

[ ] None Present
[ ] Action Taken _____
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NSN	**6505 Nonstandard**
PRODUCT	**Betuline Lotion, in 2 ounce bottles, topical methyl salicylate, OTC drug indicated for temporary relief from minor aches and pains. Recall #D-044-7.**
CODE	**Lot #55-060 EXP 04/97.**
MANUFACTURER	**Ferndale Laboratories, Inc., Ferndale, Michigan.**

RECALLED BY Manufacturer, by letter on September 27, 1996. Firm-initiated recall ongoing.
DISTRIBUTION Illinois, Indiana, Kansas, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania.
QUANTITY 17,640 bottles were distributed.
REASON Potency is not assured through expiration date -- One stability lot is subpotent for methyl Salicylate.

[ ] None Present
[ ] Action Taken _____
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NSN 6505 Nonstandard
PRODUCT Dermaline Skin-Bleaching Cream, packed in 1 ounce, 2 ounce and 4 ounce plastic jars, a non-prescription skin cream. Recall #D-045-7.
CODE IND #13505.
MANUFACTURER Leivon Cosmetics, Inc., Santo Domingo, Dominican Republic.
RECALLED BY Castillo Distributor, Inc., Little Ferry, New Jersey, by letter on October 29, 1996. Firm-initiated recall ongoing.
DISTRIBUTION New York, New Jersey.
QUANTITY Approximately 8 cases (144 8-ounce jars per case); 7 cases (144 2-ounce jars per case); 719 cases (48 4-ounce jars per case) were distributed; firm estimated that little or no product remained on market at time of recall initiation.
REASON FDA analysis found that product does not contain labeled active ingredient, hydroquinone.

[ ] None Present
[ ] Action Taken _____
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NSN 6505 Nonstandard
PRODUCT Congess SR, packaged in bottles of 100, Rx decongestant. Recall #D-047-7.
CODE Lot #6041479 EXP 2-97.
MANUFACTURER Fleming & Company, Fenton, Missouri.
RECALLED BY Manufacturer, by telephone on November 18, 1996. Firm-initiated recall ongoing.
DISTRIBUTION Nationwide.
QUANTITY 800 bottles were distributed.
REASON FDA analysis found this lot failed the release rate test -- the 4th hour release interval for

Pseudoephedrine was found to be 90%; the specification is not more than 88%.

[ ] None Present
[ ] Action Taken _____
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NSN **6515 Nonstandard**

PRODUCT **Ti-Fit (Titanium Stem) Total Hip System, Femoral Stem, Implantable Orthopedic Devices, which have not been implanted, under the following Product Numbers and Lot Numbers:**
Domestic Catalogue Numbers/Description
(a) 12-4301/Size 1 Stem, 115 mm Length, Collared
12-4302/Size 2 Stem, 120 mm Length, Collared
12-4303/Size 3 Stem, 130 mm Length, Collared
12-4304/Size 4 Stem, 140 mm Length, Collared
12-4305/Size 5 Stem, 145 mm Length, Collared
12-4306/Size 6 Stem, 150 mm Length, Collared
12-4307/Size 7 Stem, 155 mm Length, Collared
12-4308/Size 8 Stem, 160 mm Length, Collared
12-4309/Size 9 Stem, 170 mm Length, Collared
916470/Size 2 Stem, 170 mm Length, Collared
916507/Size 1 Stem, 165 mm Length, Collared
(b) 12-4331/Size 1 Stem, 115 mm Length, Collarless
12-4332/Size 2 Stem, 120 mm Length, Collarless
12-4333/Size 3 Stem, 130 mm Length, Collarless
12-4334/Size 4 Stem, 140 mm Length, Collarless
12-4335/Size 5 Stem, 145 mm Length, Collarless
12-4336/Size 6 Stem, 150 mm Length, Collarless
12-4337/Size 7 Stem, 155 mm Length, Collarless
12-4338/Size 8 Stem, 160 mm Length, Collarless
12-4339/Size 9 Stem, 170 mm Length, Collarless
Foreign Catalog Numbers/Description
(c) 52-4301/Size 1 Stem, 115 mm Length, Collared
52-4302/Size 2 Stem, 120 mm Length, Collared
52-4303/Size 3 Stem, 130 mm Length, Collared
52-4304/Size 4 Stem, 140 mm Length, Collared
52-4305/Size 5 Stem, 145 mm Length, Collared
52-4306/Size 6 Stem, 150 mm Length, Collared
52-4307/Size 7 Stem, 155 mm Length, Collared
52-4308/Size 8 Stem, 160 mm Length, Collared
52-4309/Size 9 Stem, 170 mm Length, Collared
(d) 52-4331/Size 1 Stem, 115 mm Length, Collarless
52-4332/Size 2 Stem, 120 mm Length, Collarless
52-4333/Size 3 Stem, 130 mm Length, Collarless

52-4334/Size 4 Stem, 140 mm Length, Collarless
52-4335/Size 5 Stem, 145 mm Length, Collarless
52-4336/Size 6 Stem, 150 mm Length, Collarless
52-4337/Size 7 Stem, 155 mm Length, Collarless
52-4338/Size 8 Stem, 160 mm Length, Collarless
52-4339/Size 9 Stem, 170 mm Length, Collarless
(e) 71971403/Custom made product
71971404/Custom made product
71971405/Custom made product
71971406/Custom made product
71971407/Custom made product
914334/Custom made product.
Recall #Z-135/139-7.

CODES **The following lots, all of which were manufactured prior to October 1994 and shipped to domestic accounts, are subject to recall:**
Seven (7) digit Lot Numbers beginning with the following:
1U; 2U; 3U; 4U; 1W; 2W; 3W; 4W; 1X; 2X; 3X; 4X; 1Y; 2Y; 3Y; 4Y; 1Z; 2Z; 3Z; 4Z; 1A; 2A; 3A; 4A; 1B; 2B; 3B; 4B; 1C; 2C; 3C; 4C; 1D; and 2D.
Ten (10) digit Lot Numbers beginning with the following:
405; 406; 407; 408; and 409
The following lots, all of which were shipped to foreign accounts, are subject to recall:
1. All lot numbers beginning with the letter "T" that have only eight (8) digits, indicating production before 1989; and,
2. All lot numbers beginning with the letter "T", which have nine (9) or ten (10) digits and where the sixth digit (which indicates the year) is smaller than "5"; and,
3. Lots with the sixth digit as a "5" and beginning with the following digits:
T00465, T00475, T00495, T00505, T00545, T00745, T01145, T01165, T01245, T02215, T03665, T03675, T03895, T04795, T04835, T04845, T04855, T04865, T05725, T05735, T07875, and T07885 and,
4. Lots with the sixth digit as a "6" and beginning with the following digits:
T00226, T00236, T00246, T00256, T00266, T00276, T00286, T00296, T00306, T00316, T00336, T00346, T00356, T00366, T00376, T00386, T00396, T01436, T01466, T01496, T01506, T01516, T03326, T03356, T03436, T03476, T03976, T06396, and T06406.

MANUFACTURER **Smith & Nephew Richards, Inc., Smith & Nephew Orthopedics, Memphis, Tennessee.**

RECALLED BY Manufacturer, by letter on September 26, 1996. Firm-initiated recall ongoing.
DISTRIBUTION Nationwide and international.
QUANTITY 4,200 systems were distributed.
REASON Laser etching may cause the femoral stems to fracture in use, requiring revision surgery to replace the broken hip implant.

[ ] None Present
[ ] Action Taken _____
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NSN 6515 Nonstandard
PRODUCT Condylar Bone Screws, Catalog #CS027-08/10. Recall #Z-145-7.
CODE Lot #2076.
MANUFACTURER Komet Medical, Savannah, Georgia (supplier of screws).
RECALLED BY TMJ Implants, Inc., Golden, Colorado, by telephone, followed by letter sent by fax on October 7, 1996. Firm-initiated recall complete.
DISTRIBUTION Pennsylvania, Tennessee, Texas.
QUANTITY 8 packages of 7 screws each were distributed.
REASON Some Condylar Bone Screws were in packages labeled as Fossa-Eminence Bone Screws, and some Fossa-Eminence Bone Screws were incorrectly labeled as Condylar Bone Screws.

[ ] None Present
[ ] Action Taken _____
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NSN 6550 Nonstandard
PRODUCT Vitros 250 and 950 Reference Fluids, used as a reference fluid for potentiometric assays on the Vitros (formerly Ektachem) 950 Chemistry System and Vitros (formerly Ektachem) 250 Analyzer: (a) Vitros 250, Catalog #176 5304; (b) Vitros 950, Catalog #805 7812. Recall #Z-143/144-7.
CODE Lot numbers: (a) M2057; (b) K1423, M1460, P1492.
MANUFACTURER Johnson & Johnson Clinical Diagnostics, Rochester, New York.
RECALLED BY Johnson & Johnson Clinical Diagnostics, Rochester, New York, by letter dated September 30, 1996. Firm-initiated recall ongoing.
DISTRIBUTION Nationwide and international.

QUANTITY (a) 1,952 boxes (30 units per box); (b) 3,833 boxes (30 units per box) were distributed.

REASON A portion of these lots had a diluted electrolyte concentration that could result in a shift in the sodium and chloride results.

[ ] None Present
[ ] Action Taken _____
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URGENT DRUG RECALL:

Reference Q.A. message 6309-0031, Subject: Urgent Drug Recall, NSN's 6505-01-420-4959/6505-01-420-4960, Lot numbers: 00576P, 00786P and 00966P. The following additional lots are being voluntarly recalled by Parke-Davis , Division of Warner-Lambert Company:

NSN'S: Maybe cataloged under 6505-NS, 6505-01-420-4959, 6505-01-420-4960
PRODUCT: Fluogen (Influenza Virus Vaccine, Trivalent, Types A and B
LOT NUMBERS: 00176P, 00276P, 00586P, 00676P, 00686P, 00886P, 00986P and 01066P
REASON: Decreased potency of the A. Nanchang 933/95 (H3N2) component of the vaccine.

The recall of these lots is being extended to the physician/clinic level. The above materiel is not depot stock but could have been procured locally. These lots would have been distributed between July and September 1996. If you have any of the above materiel on hand, please stop use and promptly return to the following:

Parke-Davis
Munsonhurst Road Complex
Franklin, NJ 07416

If you have any questions, please contact Parke-Davis, Medical Affairs Department, 1-800-223-0432, Coml: 201-540-2117. Reimbursement for the returned goods and shipping cost will be made by credit memorandum or check. For any Air Force Clinical information you may contact HQ AFMOA/SCOP, Attn: Lt Col Eggert, at DSN: 297-1837, Coml: 202-767-1837.
This Confirms Q. A. message 6353-0034.

[ ] None Present
[ ] Action Taken _____
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